

SECTION

12

Other services

Dialysis

Hospice

Durable medical equipment

Chart 12-1. Total number of dialysis facilities is growing; for profit and freestanding are increasing over time

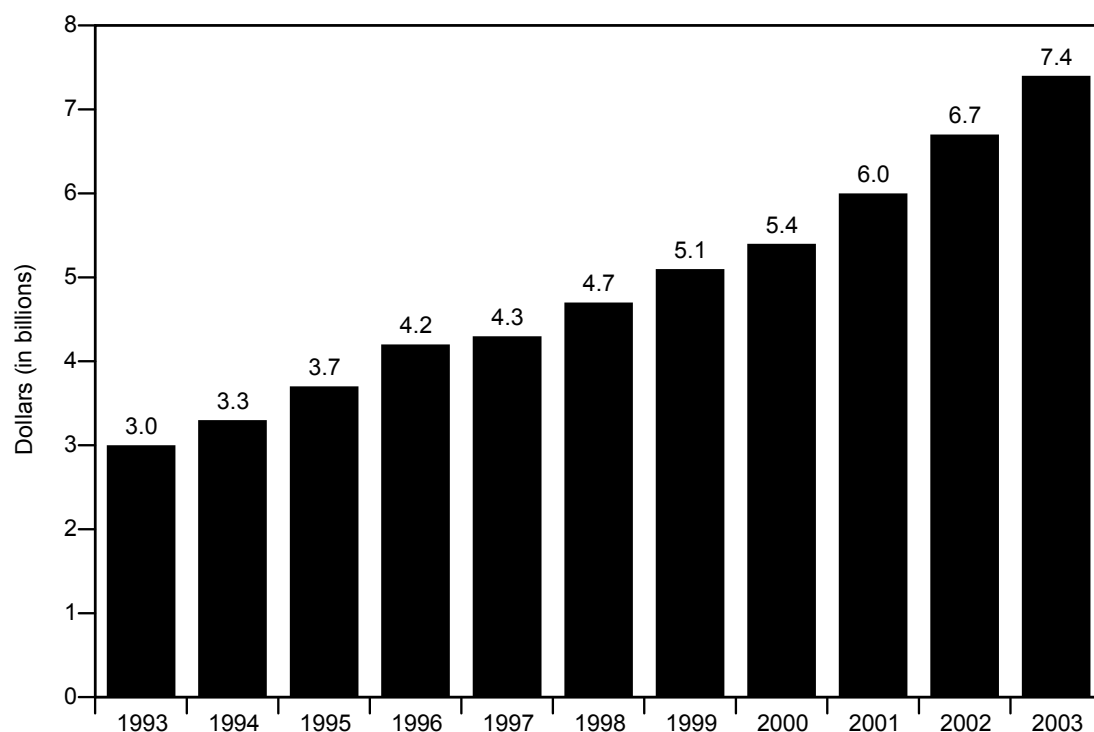
	1993	1998	2003
Total number of dialysis facilities	2,343	3,394	4,421
Mean number of hemodialysis stations	15	16	17
Percent of all facilities:			
Urban	77%	75%	75%
Rural	23	25	25
For profit	61	75	77
Nonprofit	39	25	23
Freestanding	70	79	84
Hospital based	30	21	16
Four largest chains	N/A	N/A	58
Any chain	N/A	N/A	74
Nonchain	N/A	N/A	26

Note: N/A (not applicable).

Source: Compiled by MedPAC from the CMS facility survey file.

- Between 1993 and 2003, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 70 to 84 percent of all facilities, and for-profit facilities increased from 61 to 77 percent of all facilities.
- During this time, the proportion of facilities located in rural areas has remained relatively constant.
- Specific information about each dialysis facility can be found on the CMS website, available at <http://www.medicare.gov/Dialysis/Home.asp>.

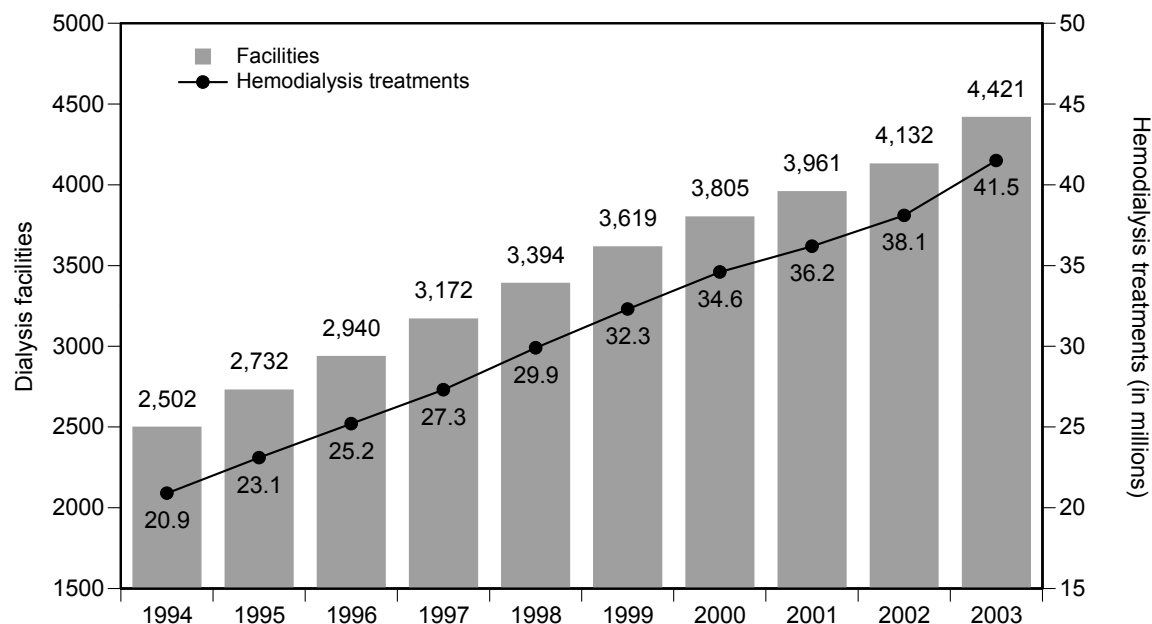
Chart 12-2. Medicare spending for outpatient dialysis services furnished by freestanding dialysis facilities, 1993–2003



Source: CMS, Office of the Actuary, 2004.

- Between 1993 and 2003, Medicare spending for both dialysis treatments (for which providers are paid a predetermined rate) and for injectable drugs administered during treatments (for which providers are paid on a per-unit basis) increased by about 9 percent per year.
- Two factors contributing to spending growth are the increasing size of the dialysis population and the growing use of injectable drugs, such as erythropoietin, iron supplements, and vitamin D analogues.
- The number of dialysis patients increased by 6 percent annually between 1993 and 2002. This growth is linked to a number of factors, including improvements in survival, as well as increases in the number of people with diabetes, a risk factor for end-stage renal disease.
- Between 1996 and 2002, estimated spending for injectable drugs increased by 17 percent annually; in contrast, spending for dialysis increased by 6 percent annually during this time period. The year 1996 is the earliest year for which this data is available.

Chart 12-3. Dialysis facilities' capacity has increased steadily between 1994 and 2003



Source: Compiled by MedPAC from the 1993–2003 facility file from CMS.

- Providers have met the demand for furnishing care to an increasing number of dialysis patients by opening new facilities. In 2003, a facility provided over 9,400 treatments per year on average.
- Between 1994 and 2003, the total number of dialysis facilities grew by about 6.5 percent annually, and the number of hemodialysis treatments grew by 7.9 percent annually.
- Specific information about each dialysis facility can be found on the CMS website, available at <http://www.medicare.gov/Dialysis/Home.asp>.

Chart 12-4. A disproportionate number of dialysis facilities that closed were small, nonprofit, and hospital based

Characteristics of facilities	Between 2003 and 2004	
	Facilities remaining open	Closed facilities
Mean number of hemodialysis stations	17.3	12.2
Percent of all facilities:		
Nonprofit	24%	46%
Hospital-based	15	44
Rural	24	26
In HPSAs	10	7
Percent of households receiving public assistance	4	4
Percent of population that was African American	18	24

Note: HPSA (health professional shortage area).

Source: Compiled by MedPAC from the 2003–2004 Facility Survey file from CMS and from the Bureau of the Census.

- Facilities that closed in 2004 were no more likely to be in rural, health professional shortage, or low-income areas than were facilities that remained in business between 2003 and 2004. This suggests that beneficiaries should not be having systematic problems obtaining care in these areas.
- But closures may be disproportionately occurring in areas where a higher proportion of the population is African American: 24 percent of the population was African American in areas served by facilities that closed compared with 18 percent of the population in areas served by facilities that remained open. However, the variables measuring race, income, and ethnicity are derived from area-level data. Area-level data cannot provide direct information about the causality of a relationship.

Chart 12-5. The ESRD population is growing, and most ESRD patients undergo dialysis

	1993		1997		2002	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	248.2	100%	334.3	100%	431.3	100%
Dialysis	180.9	73	244.2	73	308.9	72
In-center hemodialysis	149.1	60	210.0	63	280.4	65
Home hemodialysis	0.8	<1	1.7	1	1.2	<1
Peritoneal dialysis	27.3	11	28.6	9	24.9	6
Unknown	3.7	2	3.9	1	2.4	1
Functioning graft and kidney transplants	67.4	27	90.1	27	122.4	28

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with end-stage renal disease (ESRD) require either dialysis or a kidney transplant to maintain life. The total number of patients increased by 6.3 percent annually between 1993 and 2002.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is usually performed in a patient's home.
- Most ESRD patients undergo hemodialysis administered in dialysis facilities three times a week. Hemodialysis use is growing and use of the two types of dialysis administered in patients' homes—peritoneal dialysis and home hemodialysis—is declining.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living or a cadaveric kidney donation. Of the 15,712 kidney transplants performed in 2002, 40 percent of the kidneys were from living donors and 60 percent were from cadaver donors.
- This table includes both patients who are and are not Medicare eligible. In 2002, about 93 percent of dialysis patients were Medicare eligible; Medicare was the primary payer for about half of all kidney transplants.
- Information on the incidence and prevalence of patients with renal disease can be found on the US Renal Data System website, available at <http://www.usrds.org>.

Chart 12-6. Diabetics and the elderly are the fastest growing segments of the ESRD population

	Percent of total in 2002	Annual percent change 1996–2002
Total (n = 431,284)	100%	6%
Age		
0–19	2	3
20–44	21	2
45–64	42	7
65–74	20	5
75+	15	8
Sex		
Male	55	6
Female	45	5
Race/Ethnicity		
White	62	5
African American	31	5
Native American	1	5
Other	6	10
Underlying cause of ESRD		
Diabetes	36	8
Hypertension	24	5
Glomerulonephritis	16	4
Other causes	25	4

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among hemodialysis patients, about 45 percent are over age 65. About 60 percent are white.
- Diabetes is the most common cause of renal failure.
- The number of hemodialysis patients increased by 6 percent annually between 1996 and 2002. Among the fastest growing groups of hemodialysis patients are those who are over age 75 and those with diabetes as the cause of kidney failure.
- Information on the incidence and prevalence of patients with renal disease and their demographic and clinical characteristics can be found on the U.S. Renal Data System website, available at <http://www.usrds.org>.

Chart 12-7. Aggregate margins vary by type of freestanding dialysis facility, 2003

Type of facility	Aggregate margin
All facilities	4.2%
Urban	4.6
Rural	3.1
For profit	4.4
Nonprofit	0.8
Four largest chains	5.4
Other chains	0.4
Nonchain	-0.7
Furnishes per year:	
≤ 10,000 treatments	-0.9
> 10,000 treatments	6.2

Note: Margins include payments and costs for composite rate services and injectable drugs. Margins are adjusted to reflect MedPAC's analysis of audited cost reports, which found that the ratio of allowable to reported cost per treatment for composite rate services is 95.5 percent.

Source: Compiled by MedPAC from the 2001 and 2003 cost reports and the 2003 institutional outpatient file from CMS.

- For 2003, the adjusted aggregate Medicare margin for composite rate services and injectable drugs was 4.2 percent.
- Aggregate margins vary based on a facility's size, affiliation with the four largest chains, and profit status. This finding stems from differences in the cost per treatment; for example, total cost per treatment was 7 percent lower for facilities affiliated with the four largest chains than for facilities not affiliated with these chains. In addition, this finding also reflects differences in the proportion of payments facilities receive from composite rate services, which are less profitable than dialysis injectables.
- Aggregate margins for composite rate services and injectable drugs declined from 7.6 percent in 1999 to 4.2 percent in 2003. During this period the composite rate increased twice, by 1.2 percent in 2000 and 2.4 percent in 2001. Providers' cost per treatment for composite rate services spiked between 2000 and 2002, which is discussed earlier in this section. Although providers' cost per treatment for dialysis injectables increased during this period, the difference between payments and costs remained about the same.
- Between 1999 and 2003, the aggregate Medicare margin for composite rate services and injectable drugs remained positive for the majority of facilities. Among facilities that reported cost information in both 1997 and 2003, 67 percent had positive margins in both years. Only 8 percent of facilities had negative margins in both years.
- More information about the financial performance of dialysis facilities can be found in Chapter 2E of the MedPAC March 2005 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02e.pdf.

Chart 12-8. The number of freestanding and for-profit hospices has increased the most

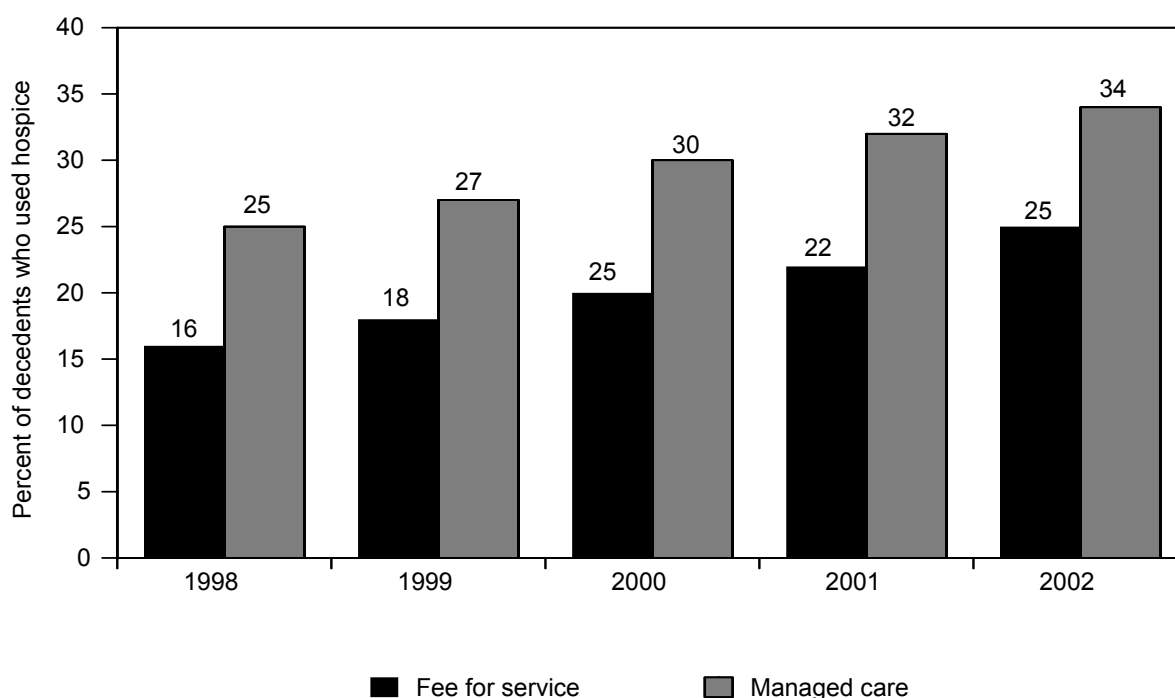
	Number of hospice facilities			Percent change 2001–2003
	2001	2002	2003	
All hospices	2,266	2,323	2,454	8
Hospice type				
Freestanding	949	1,067	1,222	29%
HHA based	744	677	653	–12
Hospital based	553	560	562	2
SNF based	20	19	19	–20
Ownership				
Not for profit	1,340	1,339	1,384	3
For profit	706	762	883	25
Government	187	188	189	1
Other	35	34	34	–3

Note: HHA (home health agency), SNF (skilled nursing facility).

Source: MedPAC analysis of unpublished data from CMS.

- The Medicare hospice benefit is specifically targeted to Medicare beneficiaries with a terminal illness. It covers a broad set of palliative services for beneficiaries whose physicians have determined that, if their illness runs a normal course, they have a life expectancy of six months or less. To elect the hospice benefit, beneficiaries must agree to forgo curative treatment for their terminal condition. The vast majority of hospice care is provided in patients' residences (i.e., their home or their nursing home).
- Hospice volume—measured by the hospice census—has also increased. Over the last several years, the number of high-volume hospices has grown, but the number of low-volume hospices has fallen.
- Between 2001 and 2003, the number of for-profit hospices increased considerably more than hospices with other types of ownership. Specifically, the number of for-profit hospices grew by 25 percent, while the number of not-for-profit and government hospices grew only 3 and 1 percent, respectively.
- Similarly the growth in freestanding hospices (not owned by another type of provider) from 2001–2003 has been much higher (29 percent) than other types (owned by home health agencies, hospitals and skilled nursing facilities).
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of MedPAC's June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

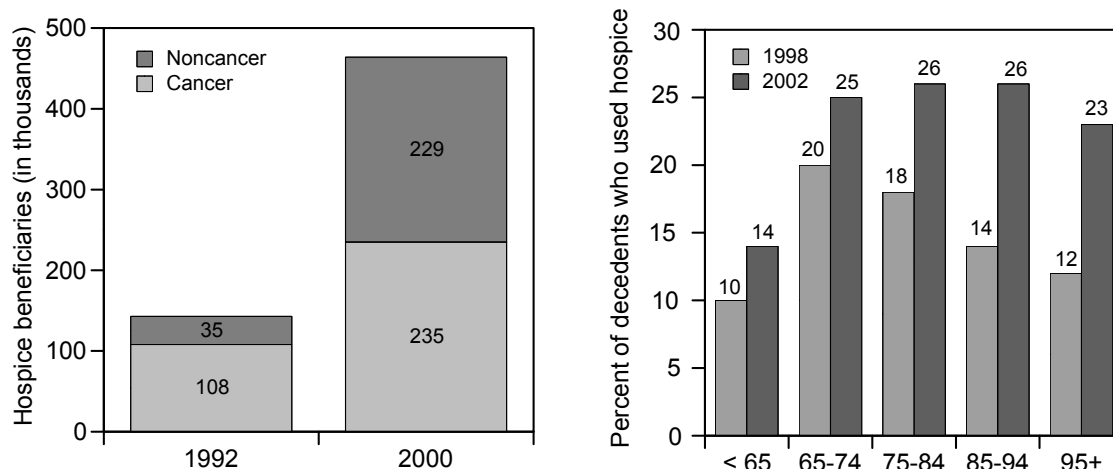
Chart 12-9. Hospice use has grown and remains higher for decedents in managed care



Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

- From 1998 to 2002, the total percentage of beneficiaries using hospice in the year before they died grew from 20 percent to 26 percent. Beneficiaries in managed care are more likely to use hospice care than beneficiaries in the fee-for-service program. Between 1998 and 2002, the percentage of beneficiaries who used hospice before they died grew from 25 percent to 34 percent in managed care, and from 16 percent to 25 percent in fee-for-service.
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of MedPAC's June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

Chart 12-10. Growth in hospice use is greatest among beneficiaries with noncancer diagnoses and those who are older



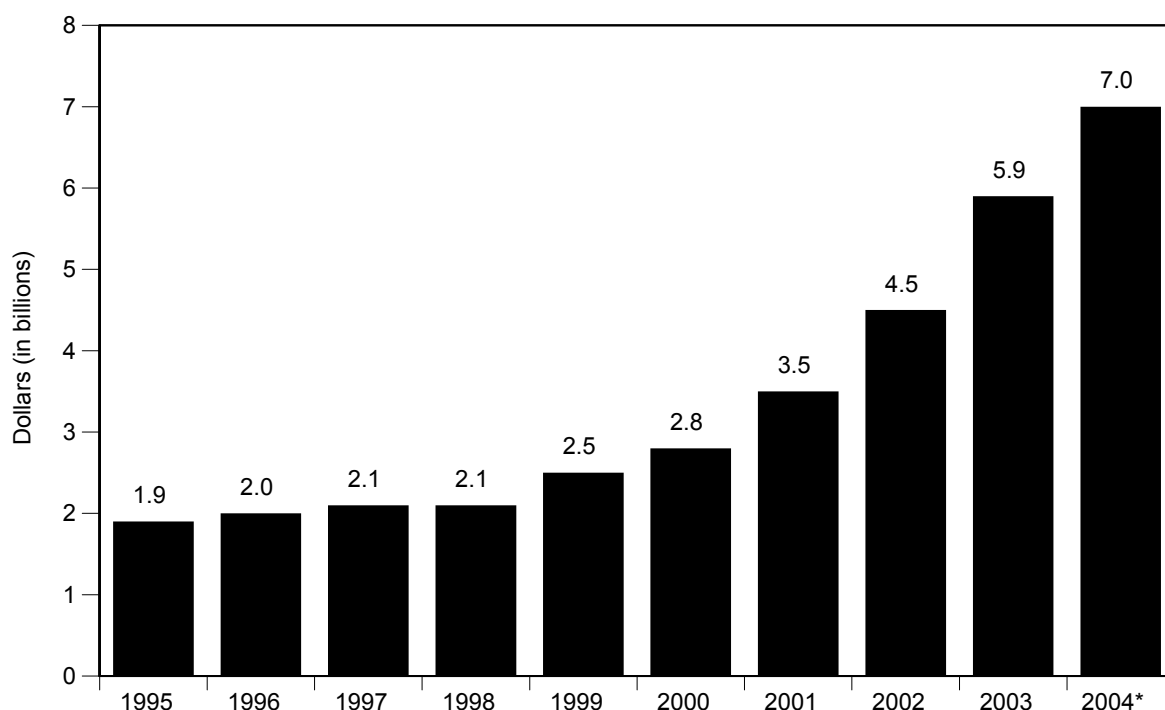
Source: Direct Research, LLC.

Note: Excludes beneficiaries in managed care.

Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

- Growth in the use of hospice has occurred among beneficiaries in all age, race, and sex groups.
- Growth in hospice use has been fastest among older Medicare decedents. Between 1998 and 2002, the share of beneficiaries age 95 or older who died while in hospice care rose from 12 percent to 23 percent.
- The growing use of hospice by the oldest Medicare decedents is consistent with findings that hospice use has increased considerably among decedents in nursing facilities. From 1992 to 2000, use of hospice by decedents in nursing facilities grew from 11 percent to 36 percent.
- The share of hospice patients with noncancer diagnoses has grown to be about half the hospice population. The three most common noncancer diagnoses for hospice patients are congestive heart failure, dementia, and lung disease.
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

Chart 12-11. Recently, Medicare spending for hospice services has increased sharply



Note: *Estimated spending for 2004.

Source: CMS Office of the Actuary.

- Consistent with increases in the number of hospice users, Medicare spending for hospice care has increased. Spending has grown from an estimated \$3.5 billion in 2001 to an estimated \$7.0 billion in 2003—a 26 percent average annual increase.
- Medicare makes daily (per diem) payments to hospice agencies for each day a beneficiary is enrolled in the hospice benefit. Payments are made through a fee schedule with four different levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. The majority of care—95 percent—is provided at the routine home care level.

Chart 12-12. Median stays remain stable while long stays grow rapidly

	Length of stay (in days)			
	Mean	25 th percentile	Median	90 th percentile
1998	52	6	18	123
1999	51	6	17	129
2000	51	6	16	130
2001	50	6	16	133
2002	55	5	16	147

Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

- In most cases, a beneficiary's length of enrollment in hospice is determined by the number of days a beneficiary lives after electing the hospice benefit.
- Between 2001 and 2002, the average length of enrollment for a beneficiary in hospice care increased from 50 days to 55 days, but the median remained 16 days.
- A consistent subset of the hospice population has short lengths of stay. From 1998 to 2002, more than 25 percent of hospice beneficiaries were enrolled in hospice for less than a week.
- Long stays are getting longer. The length of stay at the 90th percentile has steadily increased. The increased prevalence of nursing home residents in the hospice population may be a factor in this long-stay trend.
- Additional information and analysis related to the Medicare hospice benefit can be found in Chapter 6 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf.

Chart 12-13. Program payments continue to grow for durable medical equipment

	2001 payment (millions)	2002 payment (millions)	2003 payment (millions)	Percent change 2001-2003
Medical/surgical supplies	728	848	947	31%
Hospital beds	364	380	414	14
Oxygen, oxygen supplies	1,543	1,734	1,913	24
Wheelchairs	792	1,121	1,456	84
Orthotic devices	739	877	1,087	47
Drugs administered through DME	694	855	1,067	54
Other DME	557	667	817	47
Total	\$5,417	\$6,482	\$7,701	42

Note: DME (durable medical equipment). Beneficiaries are responsible for a 20 percent copayment for durable medical equipment. DME items are grouped by BETOS (Berenson-Eggers Type Of Service) codes into similar—but not necessarily homogenous—categories.

Source: CMS physician/supplier data by BETOS. www.cms.hhs.gov/data/betos/cy2003.asp.

- DME spending grew 20 percent from 2001 to 2002 and 19 percent from 2002 to 2003.
- The fastest growing category from 2001 to 2003 was wheelchairs. This category has been growing rapidly for several years. CMS, the HHS Office of the Inspector General and others have investigated wheelchair suppliers in initiatives such as Operation Wheeler Dealer. CMS has also refined the current coverage of mobility assistive equipment. Information on the most recent national coverage decision is available at <http://www.cms.hhs.gov/mcd>.
- Additional historic Medicare Part B physician and supplier data can be found on the CMS website, available at <http://cms.hhs.gov/data/betos>.
- CMS will implement a system of competitive bidding to determine DME prices in 2007.

Web links. Other services

Dialysis

- The US Renal Data System provides information about the incidence and prevalence of patients with renal disease, their demographic and clinical characteristics, and their spending patterns.
<http://www.usrds.org>
- The National Institute of Diabetes & Digestive & Kidney Diseases and the National Kidney Foundation provide health information about kidney disease for consumers.
<http://www.niddk.nih.gov/>
<http://www.kidney.org/>
- CMS provides specific information about each dialysis facility.
<http://www.medicare.gov/Dialysis/Home.asp>
- MedPAC's June 2005 Report to the Congress recommends changes to how Medicare pays for composite rate services and injectable drugs.
http://www.medpac.gov/publications/congressional_reports/June05_Ch4.pdf
- Chapter 2E of the MedPAC March 2005 Report to the Congress provides information about the financial performance of dialysis facilities.
http://www.medpac.gov/publications/congressional_reports/Mar05_Ch02e.pdf
- MedPAC's October 2003 report describes how Medicare could modernize the outpatient dialysis payment system.
http://www.medpac.gov/publications/congressional_reports/oct2003_Dialysis.pdf
- MedPAC's comment on revisions to payment policies under the physician fee schedule for calendar year 2004, includes changes in how to pay for services furnished by nephrologists.
http://www.medpac.gov/publications/other_reports/100603_RevPhysFeeSched_CB_comment.pdf

Hospice

- Chapter 6 of the MedPAC June 2004 Report to the Congress: New approaches in Medicare reviews trends and policy issues for the Medicare hospice benefit.
http://www.medpac.gov/publications/congressional_reports/June04_ch6.pdf
- The MedPAC May 2002 Report to the Congress: Medicare beneficiaries' access to hospice provides information on beneficiaries' access to hospice care.
http://www.medpac.gov/publications/congressional_reports/may2002_HospiceAccess.pdf
- Chapter 7 of the MedPAC June 1999 Report to the Congress examines end-of-life care and makes policy recommendations.
http://www.medpac.gov/publications/congressional_reports/Jun99%20Ch7.pdf

Durable medical equipment

- Pages 30 and 31 of the March 2002 Report to the Congress provide information about the durable medical equipment benefit.
http://www.medpac.gov/publications/congressional_reports/Mar02_Ch1.pdf